

FILED APR 27 1945

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 2282

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....  
(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 720 N. 3rd St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

Melven Roone

3. (b) If veteran, name war..... N#1

3. (c) Social Security No. Unknown

4. Sex Male / 5. Color or race White  
6. (a) Single, widowed, married, divorced / Married  
6. (b) Name of husband or wife..... Selma Roone  
6. (c) Age of husband or wife if alive 41 years  
7. Birth date of deceased..... October 16 1905  
(Month) (Day) (Year)

8. AGE: Years 39 Months 5 Days 20  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace..... Frankclay Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation..... Restaurant Owner

11. Industry or business.....

MOTHER FATHER { 12. Name..... William Roone  
13. Birthplace..... Unknown Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name..... Lottie Castel  
15. Birthplace..... Unknown Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant..... Selma Roone  
(b) Address..... 720 N. 3rd St.

17. (a) Burial (b) Date thereof..... 4-19-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Bismarck, Missouri

18. (a) Signature of funeral director..... Albert H. Hoppe

(b) Address..... 4700 Washington Blvd.

19. (a) APR 16 1945 (b) J. F. Brunck  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th  
year 1945 hour 3:05 minute A. M.  
21. I hereby certify that I attended the deceased from 3/4/45  
19. to 4/16/45 19. ;  
that I last saw him alive on 4/16/45 19. ;  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Poisoning of the heart by alcohol  
Due to.....

Due to..... alcoholism

Other conditions..... 77  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?.....  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of injury.....

23. Signature..... Ellis J. [unclear] (M. D. or other).....  
Address..... 1515 Lafayette St. Date signed 4/16/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Robert N. Hopp*

Licensed Embalmer No..... *156N*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 3382

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution St. Louis City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Melvin Roome  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_  
7. Birth date of deceased Oct 16 1905  
(Month) (Day) (Year)

8. AGE: Years 39 Months 5 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) APR 26 1945 (b) J. J. Bruesch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month April day 16 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

(Immediate cause of death) \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

11702